Assessing Infant Breastfeeding Beliefs Among Low-Income Mexican Americans

Sara L. Gill, PhD, RN, IBCLC
Elizabeth Reifsnider, PhD, RNC, WHNP
Angela R. Mann, RN, MSN, MPH
Patty Villarreal, MS, RN, CPNP, FAAN
Mindy B. Tinkle, PhD, RNC, WHNP

SARA GILL is an assistant professor in the Department of Family Nursing Care, School of Nursing at the University of Texas Health Science Center at San Antonio. ELIZABETH REIFSNIDER is an associate professor in the Department of Chronic Nursing Care, School of Nursing at the University of Texas Health Science Center at San Antonio. ANGELA MANN is a former graduate student from the Schools of Nursing and Public Health University at the Texas Health Science Centers at San Antonio and Houston. PATTY VILLARREAL is a pediatric nurse practitioner for the San Antonio Metropolitan Health District in Texas. MINDY TINKLE is the intramural program director for research and training at the National Institute of Nursing Research, National Institutes of Health, in Bethesda, Maryland.

Abstract

Focus groups were conducted with low-income, pregnant women and new mothers receiving services from the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC program) along with their male partners and their mothers. All participants were Hispanics of Mexican American origin. The topics for the focus-group discussions were breastfeeding beliefs and perceptions. All participants were aware of the benefits of breastfeeding. Participants identified time, embarrassment, and pain as barriers to breastfeeding; discussed decision-making efforts regarding breastfeeding; identified cultural beliefs related to breastfeeding; and discussed the lack of care-provider support for breastfeeding.

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Introduction

Breastfeeding rates nationwide are low, especially among low-income, less-educated, and minority women. Objective 16–19 of *Healthy People 2010* (U.S. Department of Health and Human Services [USDHHS], 2000) specifically states that 75% of postpartum women should initiate breastfeeding, 50% should be breastfeeding at 6 months, and 25% should continue until their child is 1 year old. In 2001, 69.5% of women initiated breastfeeding and 32.5% continued for six months (Ross Products Division, Abbott Laboratories, 2001). These rates reflect infants who received any breastfeeding.

Low-income, minority groups experience a higher prevalence of health problems; therefore, the health benefits of breastfeeding could positively impact this population. Unfortunately, low-income and minority women currently have a lower probability of initiating and maintaining breastfeeding than other women. Therefore, a cost-effective intervention that is culturally sensitive and can be easily implemented at the community level is needed to increase breastfeeding initiation and duration among low-income women. To this end, it is also important for health-care providers to understand the factors that surround mothers' feeding decisions so as to impact their attitudes, social support, and behavioral control issues, therefore increasing breastfeeding incidence and duration and decreasing infant mortality and morbidity. The development of such an intervention must be based on the beliefs and attitudes of the persons for whom the intervention is created in order to be applicable. This article describes the first steps in discerning the beliefs and attitudes about breastfeeding that are held by the population of interest.

Literature Review

Breastfeeding Benefits

Breastfeeding is the optimal source of nutrition for infants. Both the health and psychological benefits are well documented in the literature. Breastfed babies have fewer respiratory infections (Wright, 1989), fewer gastrointestinal upsets (Ho, Glass, & Pinskey, 1988), fewer ear infections (Saarinen, 1982), and fewer allergies (Cunningham, 1991). Breast milk is species specific. It is easy to digest and contains every element necessary for health, growth, and development. In addition, breastfeeding improves cognitive development (Bowes, 2002; Morrow-Tlucak, Haude, & Ernhart, 1988).

Breastfeeding also benefits mothers. These benefits include the faster return of the uterus to its prepregnant state and more rapid weight loss postpartum (Lawrence, 1999). Long-term benefits of breastfeeding include reduced risk of osteoporosis and obesity (Lawrence, 1999). Current research findings demonstrate that women who breastfeed for 20 consecutive months decrease their risk of breast cancer by 25% (Hirose, 1995). Additionally, breastfeeding is both economical and ecologically sound.

Breastfeeding Rates

Rates of breastfeeding initiation and continuation vary by ethnicity and income levels. College-educated, Caucasian women who are older than 35 years are most likely to initiate breastfeeding. Currently, 66% of Hispanic infants born in U.S. hospitals receive breast milk while in the hospital, and only 28% receive breast milk at age 6 months (Ryan, 1997). Acculturation to an American lifestyle is strongly associated with a failure to initiate breastfeeding (Rassin et al., 1994). Studies have demonstrated that, generally for Hispanic mothers, the most important predictor variable for breastfeeding is support from their mothers; however, the influence of physicians, friends, and male partners is also important (Baranowski et al., 1983). Level of educational attainment does not appear to be an independent predictor of breastfeeding for Hispanic mothers, as it is for Caucasian mothers (Bee, Baranowski, Rassin, Richardson, & Mikrut, 1991). Hispanic mothers have been found to wean earlier and introduce formula and solid foods earlier than other mothers (Wright, Holberg, & Taussig, 1988).

Breastfeeding Choices of Low-Income Mothers

The reasons low-income women in general do not breastfeed and instead choose formula include the belief that breastfeeding is painful, the lack of a supportive environment, embarrassment about nursing in public, concern that breastfeeding is restrictive and inconvenient, and the need to return to work or school (Raisler, 2000). Women who initiate breastfeeding, but wean prematurely, often do so because of perceived inadequate milk supply, maternal fatigue, and sore nipples (Milligan, Pugh, Bronner, Spatz, & Brown, 2000). Milligan and colleagues (2000) identified seven factors associated with low-income women choosing to discontinue breastfeeding: "postpartum fatigue, breast discomfort, anxiety and depression, age, number of children, social support, and prior breastfeeding experience" (p. 247).

From a public health standpoint, it is important first to assess what factors affect women's intention to breastfeed, and then to analyze the obstacles that prevent women from carrying out their desires (Balcazar, Trier, & Cobas, 1995).

Breastfeeding Among WIC Mothers

Focusing on the incidence and duration of breastfeeding, Reifsnider and Eckhart (1997) examined the effect of two specific breastfeeding educational sessions among low-income, pregnant women who received services from the WIC program. The experimental group received targeted breastfeeding instruction, while the control group received routine WIC prenatal education. Reifsnider and Eckhart concluded the incidence of breastfeeding was no different between the two groups; however, the experimental group breastfed for a mean of 76 days compared to a mean of only 30 days in the control group.

In contrast, a study conducted by Ertem, Votto, and Leventhal (2001) in the northeastern region of the U.S. reported WIC mothers who lacked confidence that they would be breastfeeding at 2 months and who believed the baby preferred formula were more likely to cease breastfeeding in the first two weeks postpartum. The mother's knowledge about breastfeeding (particularly its benefits) and problems with lactation (including the perception of insufficient milk supply) were not associated with breastfeeding attrition.

In the WIC Infant Feeding Practices Study, the U.S. Department of Agriculture (2001) reported 31% of WIC mothers initiated breastfeeding and only 16% continued until their infant turned 5 months old. By 13 days old, 25% of the infants whose mothers initiated breastfeeding were weaned from the breast. Half of the breastfeeding WIC mothers ceased breastfeeding by the second month (57 days). The researchers reported Hispanic mothers breastfed longer at 5 months than Caucasian and African American mothers. Significant numbers of breastfed WIC infants were also supplemented early on with formula. During the first five days of life, 25% of breastfeeding WIC infants were given formula, while 50% were given formula by the first 16 days of life.

Researchers conducting the WIC Infant Feeding Practices Study (USDA, 2001) also found that attitudes and beliefs about breastfeeding differ between breastfeeding and formula-feeding WIC mothers. In this study, nonbreastfeeding mothers were more likely to express uncertainty about various statements concerning the consequences of breastfeeding. Attitudes and beliefs varied across race and ethnicity. Hispanic mothers reported the most awareness about breastfeeding benefits, whereas African Americans reported the most concern about the barriers to breastfeeding. The researchers found that these attitudes and beliefs can be associated with breastfeeding practices and duration. In other words, women with positive attitudes about breastfeeding were less likely to supplement and more likely to breastfeed longer.

Varied attitudes and beliefs among ethnic groups can be associated with breastfeeding practices and duration.

Breastfeeding Among Hispanic Women

It is not clearly understood why more Hispanic women do not initiate breastfeeding (Balcazar et al., 1995). The literature reports that the more acculturated Hispanic women are to the United States, the less likely they are to breastfeed (Balcazar et al., 1995; Denman-Vitale & Murillo, 1999; Rassin et al., 1994). Rassin and colleagues (1994) reported that, for women on the U.S.-Mexico border near Brownsville, Texas, the variables of degree of acculturation, age, and marital status were significantly associated with breastfeeding initiation; however, variables such as occupational status, education, and income were not significantly associated with breastfeeding initiation.

In summary, knowledge that breastfeeding is the optimal method of infant feeding is not enough to encourage women to nurse their child. Whether or not a mother breastfeeds is influenced by many interrelated factors, including cultural beliefs about infant-feeding practices. Further studies are needed to design culturally specific interventions to increase the incidence and duration of breastfeeding in specific populations.

Methods

The purpose of this qualitative study was to identify breastfeeding cultural beliefs among low-income Mexican Americans. Focus groups, lasting approximately one hour, were conducted to elicit beliefs about breastfeeding. The focus-group interviews were designed

to allow participants to share their views, attitudes, and opinions about breastfeeding in a nonthreatening environment. All conversations were tape-recorded. The recordings were transcribed for analysis. The content of the narrative data was analyzed to determine themes.

Focus groups with members of Mexican American families were conducted with 10 pregnant women, 15 new mothers, 9 men, and 5 grandmothers. Participants were recruited from the waiting room of a Texas WIC clinic at a variety of dates and times. The focus groups for the new mothers and pregnant women were conducted during a scheduled nutrition class in a private room located in the WIC clinic. The focus groups for the men and grandmothers were conducted in another private room at the WIC clinic while their partners or daughters attended a nutrition class in the same facility. Incentives for participation included a $10 gift card for the discount store, K-mart. For the particular WIC project in which the study occurred, breastfeeding rates were 74% at initiation, 40% at two months postpartum, 30% at four months postpartum, and 23.1% at six months.

Sociodemographic data were collected in order to describe the sample (see Table). A focus-group discussion guide was used to direct the conversation. These questions were also used in a similar study that was previously conducted with the WIC staff at the same clinics in which this study occurred (Reifsnider, Gill, Villarreal, & Tinkle, 2003). In the previous study, the questions yielded thick descriptions and generated discussion; therefore, the same questions were used with the current study's WIC participants and allowed for comparison between the staff members' answers and the participants' answers. Questions progressed from general to specific. The researchers asked participants the initial grand-tour question, "What do you think about breastfeeding?" This inquiry was followed by the following questions:

- What makes breastfeeding easy and what makes it hard?
- Are there foods or substances that must be avoided while breastfeeding?
- Are there foods or substances that need to be eaten while breastfeeding?
- Who helped you decide how to feed your children? How did they help you make that decision?
- What things from your culture or family background influence how you think about feeding babies?

Data Analysis

The audiotapes were transcribed and reviewed for accuracy. The first and second authors independently

Table Sociodemographic Data of Low-Income, Mexican American Hispanics Receiving Services from a Special Supplemental Nutrition Program for WIC Participants and Their Male Partners and Mothers

	No.	Age	Marital Status	Level of Education	Language Skills	No. of Children	No. of Breastfed Children	Employment	Income
Pregnant Women	10	*X* = 25.1 Range: 20–30 years old	8/10 Married	Range: 7th grade through college	All speak both English and Spanish. All can read English.	*X* = 1 Range: 1–6 children	0–3 children	Employed: 2 Unemployed: 8	$10,000–$14,999
New Mothers	15	*X* = 21.4 Range: 17–32 years old	4/15 Married	Range: 9th grade through college	All speak both English and Spanish. All can read English.	*X* = 2 Range: 1–3 children	0–2 children	Employed: 5 Unemployed: 10	$10,000–$14,999
Men	9	*X* = 25.2 Range: 15–36 years old	5/9 Married	Range: 9th grade through college	All speak both English and Spanish. All can read English.	*X* = 2 Range: 1–3 children	0–2 children	Employed: 7 Unemployed: 2	$10,000–$14,999
Grandmothers	5	*X* = 49.6 Range: 39–65 years old	2/5 Married	Range: 5th to 11th grades	2 speak Spanish only. 3 speak both English and Spanish.	*X* = 3 Range: 0–8 children	0–8 children	Employed: 3 Unemployed: 2	Under $9,999

coded the transcripts by grouping similar data together. Themes and patterns were identified. After all transcripts were coded, the first two authors met together to compare findings. Initial agreement was 95%. The fourth and fifth authors then verified the findings by reviewing the transcripts along with the coding and themes.

Results

Several themes emerged from the data: the benefits of breastfeeding, making the decision to breastfeed, the barriers to breastfeeding, lack of breastfeeding support, and cultural beliefs. These themes fit the suggested topics of the questions asked and, thus, were not a surprise.

Benefits of Breastfeeding

All pregnant women, new mothers, their mothers, and their male partners were familiar with the benefits of breastfeeding. All study participants were able to identify breastfeeding's health benefits for baby and mother, the superiority of breast milk, the nutrient content of breast milk, breastfeeding's ability to increase closeness to the baby, and the cost savings of breastfeeding.

The statements presented below typify responses to the question, "What do you think about breastfeeding?" Participants answered by discussing the benefits of breastfeeding. All women said that breastfed infants were healthier than formula-fed infants. Pregnant women responded, "Breastfeeding is healthier for the baby… the babies get less sick." Another mother echoed this comment and added, "[Babies] grow faster and fatter." Pregnant women described the emotional connection: "I think breastfeeding gets a child closer to the parents."

New mothers also described the health and emotional benefits of breastfeeding. "I felt [my baby] close to me… I bonded a lot better with her." Another mother added, "I felt much closer to her." Concerning the health benefits of breastfeeding, new mothers stated, "It makes babies healthier and less cranky, and they get fewer earaches." New mothers and pregnant women also mentioned that breast milk contained more "vitamins" than formula and that breastfed babies were smarter, slept more, and got sick less than formula-fed babies.

In addition to discussing the baby benefits of breastfeeding, women described the maternal benefits of breastfeeding. One pregnant woman related that her mother told her to breastfeed "because you could lose weight faster." Another pregnant woman said, "Your uterus shrinks up faster when you breastfeed." A new mother responded similarly when asked about the benefits of breastfeeding. She said, "It's better because, well, because of the uterus… it gets back into shape faster."

Men were also asked what they thought about breastfeeding. Their responses were similar to the women's responses. "You notice one thing about a baby when they get breastfed. They grow healthier." Another man stated, "Breast milk has more nutrition. It's really better than, you know, the milk you get from the store." The men also said that breastfeeding was "the right way, the normal way, the natural way. You're supposed to breastfeed your baby."

One man mentioned an economic advantage of breastfeeding: "It was cheaper, cheaper… because you didn't have to buy all that formula." Speaking of the benefits of breastfeeding, another man stated, "It's also that the baby gets, you know, stays with her mom. You know… bond."

Making the Decision to Breastfeed

All participants were asked when the decision to breastfeed was made, how the decision was made, and who made the decision. All of the men said the decision was entirely up to their partner. These men stated that the couple did not discuss a feeding method. One expectant father stated, "I think she's going to stay with Similac [brand feeding formula]. We haven't really talked about it." Another expectant father said, "She just wants to try the bottle. We didn't talk about it. She just sort of told me." Another also said, "I have no idea. She just came back with some WIC card and told me to come with her to get the Similac."

Pregnant women and new mothers said that they made the decision to breastfeed without input from their partners. One woman related, "I decided on my own. The only thing my husband said is, 'Watch your tit. I don't want nobody seeing it.' That's it, you know. Like in a public place, you know." Another said that her husband claimed it was her decision.

Women said they consulted female family members for advice about breastfeeding. "My mom helped me decide. She tells me it's better for me and for the baby

and I have to think about the baby now. I can't just think about myself." Another new mother said that she had talked to her sister who had attempted to breastfeed. "I made that choice on my own because my sister experienced it and she told me not to breastfeed… that it was a pain."

Grandmothers held two different opinions regarding their daughters' feeding decisions. Several grandmothers stated that their daughters made feeding decisions based on information from health-care providers or clinics. "You know, when they go to a clinic or the hospital they hear stories about breastfeeding is better or bottle-feeding is better, and that's how they decide." One grandmother said that her daughter decided from "me telling her [breastfeeding is] better."

Barriers to Breastfeeding

Focus-group participants identified three barriers to breastfeeding: embarrassment, pain, and inconvenience.

Embarrassment. All participants felt exposing their breasts in public or in front of anyone other than their partner or female family members was inappropriate. One new mother stated, "It's hard to breastfeed in public… with people watching. It's weird. I've never done it, but it's weird if you see someone doing it." Another new mother related the following story:

> We walked in and this woman was feeding her baby and we were like, "Whoa, I don't want to see that." To me, breastfeeding, I think, would be something you do in private. But if the baby is hungry, you've got to do it right there. But it just… it shocked me because I've never seen that, not in public. And she just did it. Her husband was there and I guess her father-in-law was there and they were just like nothing. And to me it was like, "Whoa," so we just kept on walking. I wouldn't do it.

Pregnant women and new mothers discussed two options for breastfeeding in public. One option was to cover the baby and the mother's breast with a blanket; another option was to feed the baby with a bottle when in public. One pregnant woman who had not decided whether or not she would breastfeed commented, "[Breastfeeding is] not really embarrassing when you're with your husband or with your girlfriend. It's not as bad if you cover yourself right…with a blanket."

Many pregnant women and new mothers believed breastfeeding in public was never appropriate. One new mother said, "[The breast] is your private part, and for you to be showing it, it is very uncomfortable for you to have it out." These women said that bottle-feeding was the only acceptable option for feeding a baby in public. A pregnant mother said, "It's better to pump before you go out. And take a bottle."

Grandmothers also stated that it was not appropriate to breastfeed in public. They offered the options of covering up or providing a bottle as an acceptable alternative. Grandmothers offered an additional option to breastfeeding in public. They said, "If you have to go out, you should go to a restroom or something."

Men claimed that their partner's breastfeeding in public would "bother" them. "Everybody would be watching and they might think wrong about her." Men felt that it was only appropriate to breastfeed at home. "I don't want her to breastfeed in front of everyone. Well, she can breastfeed at home with her sister or my sister." Another man said, "It would bother me for her to be breastfeeding the baby somewhere else instead of at home." Another man stated, "I don't want to be at a restaurant or anything, and she just lifts up her shirt, and is like feeding or anything. I don't agree with that."

Men felt that other men would have sexual thoughts if they saw their partner breastfeeding. One man, speaking about breastfeeding in public, said, "Everybody will be watching, and then they might think wrong about her. They have an ugly mind. They just think about one thing … sex."

Pain. All focus-group participants mentioned pain as a barrier to breastfeeding. They discussed their personal experiences with pain and stories that they had heard from other women regarding pain. Women discussed nipple pain, pain from engorgement, and pain from biting when the baby was teething. One new mother said that breastfeeding was hard because her nipples hurt. "I didn't know what to do… I just stuck my nipple in his mouth and I started getting purple. I don't know what he did, but I got a blister and it hurt and it started bleeding."

Pregnant women shared stories that they had heard from others regarding pain. "My sisters experienced breastfeeding and they said that it hurts around the nipple. It hurts and I don't know if I want to try it." Grandmothers did not mention pain as a barrier to breastfeeding. In fact, the grandmothers never discussed pain.

Inconvenience. Participants said that breastfeeding was inconvenient. Inconvenience related only to the amount of time that it took to breastfeed. New mothers stated the breastfed babies fed more often and took longer to eat. One new mother shared, "You have to wake up every time that he's hungry. They eat more often and you have to get up to do that."

Pregnant women also perceived breastfeeding as inconvenient. They discussed having to return to work or school after the birth of their child. One woman said, "I work, so I can't breastfeed. I don't have time." Other women said, "I worked full time, so I couldn't stay with my baby to feed." Other pregnant women said that they would not have time for themselves, their other children, or their home responsibilities if they chose to breastfeed. Another woman said, "You just have to stay at home [when you breastfeed], you can't go anywhere or do anything else."

The men claimed that breastfeeding took time and that only the woman could feed the baby. One man said, "It takes more time on the mother." They stated that this could make breastfeeding difficult. Grandmothers echoed concerns about working and breastfeeding. One grandmother said, "Well, women work now and that takes time, so they can't breastfeed."

All participants identified the use of a breast pump as a solution to breastfeeding barriers. They said that using a breast pump would allow time to do the things that they needed to do, allow them to go out and not worry about breastfeeding in public, and allow them to feed their baby expressed breast milk if their nipples were too sore to nurse. One new mother echoed the sentiments of the other participants, saying, "A breast pump would be helpful. You could pump the milk out and put it in a bottle for when you go out or when you don't have time."

Lack of Breastfeeding Support

New mothers discussed the lack of breastfeeding support from hospital staff. They reported this lack of support as a reason for discontinuing breastfeeding. One mother said:

> I didn't know what was going on with my breast and milk and things like that. I really didn't know too much, so I just stopped. I asked my mother-in-law questions, but she didn't know. I think some classes might have helped.

Mothers wanted breastfeeding support from hospital staff but felt that they did not receive it. A mother shared her experience:

> At the hospital they were just more, like, I guess they just assumed the bottle. I didn't really know whether I wanted to breastfeed or not, so they just went ahead and right away gave him the bottle.

Another mother shared her disappointment with hospital staff:

> When I had [my baby] at the hospital, I wanted to breastfeed, but I did not get no one who was going to teach me. And just me by myself, you know, I did it, and it was real painful. Because I didn't know what I was doing and my breast was always hurting. I didn't do it right, so I stopped doing it. And I think that if someone would have helped me and showed me how to do it, I think I would have still been breastfeeding my son. I tried to, but I couldn't.

Pregnant women and males did not discuss breastfeeding support. Grandmothers discussed support in terms of their inability to answer breastfeeding questions or provide technical assistance. One grandmother summarized the others' sentiments by saying, "My daughter was having problems, but I couldn't help her because I never breastfed."

Cultural Beliefs

All focus-group participants discussed practices that they believed were essential for a successful breastfeeding experience. These practices were related to foods, alcohol, smoking, and stress. All female participants discussed foods to eat and foods to avoid while breastfeeding. Comments about particular foods are presented below:

- You have to eat real good… no beans, no spicy foods. Beans will give the baby and mother gas, and spicy foods makes the milk bad. You need to eat a lot of protein, a lot of vegetables. You have to eat healthy to keep your body healthy. Drink a lot of milk. Drink a lot of juice. If you do this, you can make twice as much milk.
- Don't drink alcohol. None, not any. If you do, it will spoil the milk. I wanted to drink on my birthday, so I pumped the milk out.

- You cannot smoke while you're breastfeeding, or take medications.

Some mothers described using a special drink, called "liquado," to enrich their breast milk. Liquado is a blended drink of fresh fruit (typically, bananas or melon), sugar, milk, and egg. These mothers said they drank liquado several times a day. One woman said:

> When my mother-in-law was in town, she made me liquados. With bananas, egg, the sugar… Oh my God, my refrigerator was full of fruit where she'd just blended in milk. Sometimes she used melon. When she left to go back to Mexico, I'd be there blending the banana. She told me when I had my son about this. I had it every day.

Additionally, participants discussed avoiding stress while breastfeeding. Women who perceived their lives to be stressful would choose to bottle-feed. "You can't be stressed when you're breastfeeding. It dries up your milk." Another woman said, "If you're stressed while you're breastfeeding, the baby will get it."

Discussion

In this study, all participants knew the benefits of breastfeeding, even to the level of postpartum physiology (e.g., "it makes your uterus shrink faster"). But the knowledge of benefits to the mother and the baby did not overcome the perceived problems that breastfeeding would create, such as embarrassment, pain, and inconvenience. Formula was perceived as a suitable alternative; therefore, the women perceived no benefit in enduring the negative events that breastfeeding was believed to cause. Knowledge of physiological benefits does not overcome beliefs about how daily life will be impacted. A summary of obstacles that have been demonstrated by other researchers across many populations to impede initiation and continuation of breastfeeding include the following:

The knowledge of benefits to the mother and the baby did not overcome the perceived problems that breastfeeding would create, such as embarrassment, pain, and inconvenience.

- health-care provider apathy and misinformation;
- insufficient prenatal breastfeeding education;
- disruptive and detrimental hospital policies;
- inappropriate interruption of breastfeeding;
- early hospital discharge with some populations;
- lack of prompt routine follow-up care and postpartum home visits;
- maternal employment (especially full-time in workplaces without supportive facilities for breastfeeding);
- lack of societal and social support;
- media portrayal of formula-feeding as the norm;
- promotion and distribution of formula through hospital discharge packs;
- free formula coupons or discounted formula; and
- formula advertising (American Academy of Pediatrics, 1997; Arora, McJunkin, Wehrer, & Kuhn, 2000; Black, Jarman, & Simpson, 1998; Dennis, 2002a; Mozingo, Davis, Droppleman, & Meredith, 2000; Schanler, O' Conner, & Lawrence, 1999; Vogel, Huthchinson, & Mitchell, 2000).

All of these obstacles were named by the focus groups in this current study and in the companion study of WIC staff (Reifsnider et al., 2003). Thus, obstacles to breastfeeding appear to be universal in the United States and not limited to Mexican American mothers. Nevertheless, by using focus groups—as demonstrated here—educators can view which barriers are particularly relevant to address in the populations they serve. For example, modesty appears to be an especially strong barrier in this study group of low-income Mexican Americans.

On the other hand, support from the father of the baby and the woman's mother, family and friends, peer counselor, or lactation consultant have been shown to increase breastfeeding behaviors (Arora et al., 2000; Dennis, 2002a, 2002b; Humphreys, Thompson, & Miner, 1998; Lawrence, 1999; McKeever et al., 2002; Scott, Landers, Hughes, & Binns, 2001). In the current study, support from older women who had breastfed was seen as beneficial in promoting breastfeeding. This supports the recommendation from Meyerink and Marquis (2002) that a surrogate mater-

nal figure who helps with breastfeeding support may be the best role model for the initiation and duration of breastfeeding.

In general, mothers who have a social support network consisting of women who have breastfed or who support their breastfeeding decision are more likely to initiate and continue that feeding practice (Dennis, 2002a). Humphreys and colleagues (1998) found this particular support is especially important to low-income women. In their sample of 1,001 low-income pregnant women, they concluded that health professionals' attitudes were less influential on the women's feeding decisions than the attitudes and beliefs of the women's informal support networks. Health-care providers, including nurses, can have a negative effect on breastfeeding behaviors because of their lack of knowledge and inaccurate or inconsistent advice (Dennis, 2002a; Gill, 2001; Humphreys et al., 1998; Schanler et al., 1999).

In a study by Libbus and Kolostov (1994) of low-income Midwestern women, breastfeeding experience by the maternal grandmother and endorsement by the male partner positively affected the intention to breastfeed. Those who intended to breastfeed viewed it as easier, more convenient, and more conducive to freedom than did those who planned on bottle-feeding. Additionally, modesty issues were extremely important to the participants in Libbus and Kolostov's study. The researchers found that modesty "may also be related to the unwillingness to deviate from perceived community norms, which depict the female breast as a sexual object" (p. 21). In this current study, modesty was also perceived as a barrier to breastfeeding.

In a study conducted by Guttman and Zimmerman (2000), younger, low-income women believed their community was pro-breastfeeding; however, participants in their study also reported that their friends or peers usually disapproved of breastfeeding or even characterized it as "nasty" (p. 1471). Again, the concept of the erotic nature of breasts was raised, as well as the lack of positive role models for these women. Breastfeeding was also viewed as time-consuming, inefficient, in conflict with women's other roles and responsibilities, and "not in tune with the pace of modern life" (p. 1471).

Consistent with other studies, Richardson and Champion (1992) confirmed that older, married, and more educated mothers breastfeed longer, as do those who perceive breastfeeding to be easy and natural. However, Richardson and Champion reported that the influence and encouragement of female family members have a greater impact on breastfeeding duration. When coworkers encouraged breastfeeding, the total length of time devoted to breastfeeding increased as well. Supplementation in the first month negatively influenced duration, whereas supplementation by the fourth month positively influenced breastfeeding continuation. If the mother had previously breastfed another child, Richardson and Champion found she experienced longer breastfeeding duration with the current infant.

Culture may also play a role in the family's support of breastfeeding. Hispanic women of Puerto Rican and Cuban descent turn to their mothers for breastfeeding advice and support (Black et al., 1998). Caucasian women rely on their husbands or friends, whereas women of other ethnicities turn to close friends and relatives (Black et al., 1998). Meyerink and Marquis (2002) interviewed 150 mothers in Alabama (93% were African American women). They found that women who breastfed longer were breastfed themselves as infants and had added family support, particularly from their mothers.

The issue of acculturation also impacts breastfeeding incidence and duration. For example, mothers who recently emigrated from Mexico were more likely to choose breastfeeding than were those born in the United States or who had lived here for several years (Denman-Vitale & Murillo, 1999). In their study on the U.S.-Mexico border, Rassin and colleagues (1994) found the highest rate of breastfeeding initiation occurred among participants who were least acculturated to the United States. The researchers also found that older, married, or less U.S.-acculturated mothers were most likely to initiate breastfeeding, which is in keeping with other studies. Rassin and colleagues' (1994) finding is consistent with the results from the current study in which breastfeeding women who had support from Mexican family members had a more positive attitude toward breastfeeding.

Visness and Kennedy (1997) used the National Maternal and Infant Health Survey, conducted by the National Center for Health Statistics, to analyze the effect of maternal employment on breastfeeding initiation and duration. They concluded that returning to

work did not impact breastfeeding initiation per se, but those who had to return to work weaned earlier than those who did not. Women with longer maternity-leave opportunities breastfed longer. Additionally, Caucasian professional women, who were more likely to combine work with breastfeeding, breastfed longer. Visness and Kennedy's data did not contain information about the number of hours worked; therefore, part-time or full-time employment status could not be determined. In the current study, employment was viewed as a strong barrier to breastfeeding. This may have been reflective of the type of jobs most WIC families hold, ones that do not allow flexibility or privacy for pumping or storing milk.

Implications for Practice

This study employed focus-group methodology to learn how clients and their families in one WIC project perceived breastfeeding. On an informal basis, perinatal professionals can use this methodology to discover their clients' (pregnant women and their partners and mothers) breastfeeding attitudes and beliefs. Before providing education about breastfeeding during WIC nutrition education sessions or during prenatal classes, perinatal professionals can use the questions that were asked in this study to get a sense of what perceptions of breastfeeding are common among the class attendants. When barriers are voiced (e.g., embarrassment, pain, and inconvenience), perinatal education can be targeted to address those perceived barriers. If possible, a breastfeeding mother could demonstrate how to breastfeed in public with modesty and answer questions about nipple and breast pain and the amount of time spent in breastfeeding a baby versus preparing bottles of formula.

It is incumbent upon professionals working with pregnant women when discussing breastfeeding to address the issues of embarrassment, pain, and inconvenience. Pregnant women may not ask about these issues, but they will hear about them from their partners and mothers. The perinatal professional can anticipate that the pregnant woman will hear "horror stories" about bleeding nipples, babies at the breast for 20 hours a day, and husbands seeing exposed breasts. If the pregnant woman is informed about proper latching on, signs of infant satisfaction with nursing, the importance of building a milk supply through longer breastfeeding sessions, and other important breastfeeding topics, she will be less susceptible to believing the "horror stories" and will have the knowledge to deal with the unsupportive statements she may receive.

Information about pain can be presented as an issue that may arise initially during the first few days. However, the woman should also be taught about pain that is transitory and occurs with milk let-down and pain that is associated with poor latch-on practices and cracked nipples. Similarly, the pregnant woman should be informed of breastfeeding tips (as outlined in the Box).

Perinatal professionals can address the issue of modesty by demonstrating discrete ways to access a breast, such as the mother's wearing nursing bras and two-piece outfits. For women who refuse to consider nursing outside the home, a breast pump may be the answer. They can be taught how to pump their milk and keep it in storage. When mothers need to leave the home with or without their infants, the infants can be fed breast milk, which will maintain the mothers' milk supply and the healthy advantage of breast milk for the infant.

Objective 16–19 of *Healthy People 2010* specifically states that 75% of postpartum women should initiate breastfeeding, 50% should be breastfeeding at six months postpartum, and 25% should continue until their child is 1 year old (USDHHS, 2000). These objectives will not be met unless attitudes change about breastfeeding. The most potent way to accomplish this change is for some mothers to breastfeed successfully, spread the word, become supportive of other breastfeeding mothers, have husbands who become breastfeeding supporters, and change the common perception of breastfeeding as immodest, painful, and inconve-

Box Sample Breastfeeding Tips for New Mothers

- A neonate will nurse 8 to 12 times a day, which is necessary for the infant's weight gain and growth.
- Nursing while lying down can conserve energy and be used as a time to grow closer to your baby.
- Holding an infant when it is bottle-fed is important. Infant feeding will take time, whether the infant is breastfed or bottle-fed.

nient. Perinatal professionals can influence this change by addressing mistaken attitudes about breastfeeding and providing correct information and support to new mothers and their families.

Perinatal professionals can address mistaken attitudes about breastfeeding and provide correct information and support to new mothers and their families.

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Diversity and Cultural Awareness

Language (and learning) is essentially rooted in the reality of the culture, the life and customs of a people, and it cannot be explained without constant reference to these broader contexts.

—Bronislaw Malinowski

Exploring the culture of learning in a given context is not an easy undertaking. It calls for a study of the deeply rooted cultural and educational traditions of the target society. It calls for a willingness to invest both the time and the effort to understand students' behaviors in terms of the meaning which they have for them in the light of their own beliefs and assumptions.

—Ian Tudor

We have become not a melting pot but a beautiful mosaic. Different people, different beliefs, different yearnings, different hopes, different dreams.

—Jimmy Carter

It were not best that we should all think alike; it is difference of opinion that makes horse races.

—Mark Twain